Personal Care Workers - SET THE PACE

Provider Resource Guide
For Personal Care Care Workers
Message from the Chief Health Officer

The Department of Veterans’ Affairs (DVA) is focused on promoting a person-centred approach across all programs delivering services to veterans and their families. By ‘person-centred’, I mean care that is determined by the needs of the veteran, or entitled family member. DVA is committed to assisting community nurses and personal care workers deliver the very best person-centred care. I trust this resource will support you in the delivery of community nursing services and thank you for your care of our veterans and their family members.

Dr Loretta Poerio
A/g Chief Health Officer

Introduction

Nursing Support Staff (NSS) are the ‘front line’ of support services. Also known as Personal Care Workers (PCWs) or Care Workers in the community, they are the people who spend the most time with clients and get to know their day-to-day lives.

As a PCW, you are often the first person to notice any changes (variances) in the person you are providing care for. Even a small variance can be a sign that the person might need more support, less support, or a different kind of support.

Writing down what happens at a visit is important, even if just to say you delivered care as per the person’s plan. This is because your records build a picture of the client over time. They help identify what is ‘normal’, and what might need attention from a nurse, doctor, family, or other support services.
Within the community nursing program, Nursing Support Staff work under the delegation of a Registered Nurse (RN), so when you write a variance, in a client’s progress notes, you will need to report this to your RN or manager.

If you aren’t sure what to document, remember that your most important information-gathering tools are your senses – your sight, your hearing, your touch, and sense of smell. During the visit, ask yourself questions like: What does the client look like? How do they sound and what are they telling me? If you write down exactly what you observe, and follow the guidelines in this book, you will create accurate documentation that meets your agency standards.

In addition to progress notes, your workplace policies and processes may require special reporting. This covers situations like incident reporting, assisting with medication, and medication prompting.

You need to complete documentation for each person who uses your service. This guide has been developed to help you check and make sure that your documentation is high quality. Work through each section in this book, and then study the sample personal care plans. Using the PACE method, you will learn how to create useful, accurate documentation, even if your workplace care plans look different to the examples in this booklet.

**NOTE: throughout this guide, ‘client’ is used to describe any person you support, whether they are a veteran or someone related to a veteran.**
Exercise 1: Why do I document?

Use the space below to note all the reasons you write things down at work:

Look at the following list and tick which reasons you think you covered in your answers:

☐ A reminder
☐ A list of things to do
☐ To tell someone else to do something
☐ To ask for information
☐ To create a record
☐ As an audit tool
☐ To educate others
☐ As a legal record in a legal situation
The common reason for all documentation is to communicate in some way. And because you can never be sure who you are communicating with, you need to write in a way that everyone will understand.

Whatever you write, you are always giving information to another person, so it’s important to get it right!

The next section looks in more detail at some techniques that will help you complete your documentation to standard.

NOTES:
The impact of good documentation

Documentation is part of high-quality support and assistance, not an ‘add on’ or ‘extra’. Poorly written information leads to confusion and mistakes as people can interpret words differently. Clients are relying on you to keep accurate records as part of their overall care.

You do not have to write an essay! If you follow some simple guidelines, your information will always be useful to others.

Accurate, up-to-date documentation means:

• We all get the same information
• We all understand the information in the same way
• We all use the same words
• We do it the same way – it is consistent
• We are working toward the same goals
• We learn how things are done the same way
• We rely on processes rather than people to remember
• We can easily see what was or was not done
• We can find records more easily if needed
• We show that we are professional
• We reduce potential errors and incidents
If you are completing client documentation just to keep a legal record, you’re doing it for the wrong reasons!

A record only becomes a legal document if subpoenaed by a court of law.

Focus on why you write things at work and use this guide to help confirm your documentation is useful.

The next few pages will help you to complete records and documentation that is relevant, current, reliable and valuable.

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Keeping PACE - a handy way to document accurately!

You already know that support and care services use a lot of abbreviations and acronyms – words made using the first letters of other words. A good example is NSS, for Nursing Support Staff. You may be called Personal Care Workers – PCWs – or a similar title depending on your workplace.


If in doubt about your documentation, PACE yourself. The next few pages explain how PACE works.
Person-centred documentation means that everything you write about a client’s care is about them, and from their perspective, rather than yours.

Using a person-centred approach to care, all documentation should have the person (client) as the focus, with the support around them.

The following examples show what is meant by person-centred.
Notice the difference between what you did (helped Mr Johnson in the shower) and what Mr Johnson did (had a shower with assistance).

The first example is all about the care worker completing a ‘task’. The second example is person-centred – what Mr Johnson did for himself. Can you see the pattern with the other two examples?

By taking the focus away from the task and onto the person, you add a lot more useful detail for anyone reading the documentation. Others will now know that:

- Mr Johnson only needed assistance washing his back, otherwise he washed himself.
- Mrs Fenton needed full assistance toileting.
- Mr Joseph ate independently; he just needed prompting and supervision.

Person-centred documentation like this can be measured against identified care needs and the person’s care plan. It also helps identify variances, which leads to much better care outcomes for the person.
PACE - ‘Accurate’

‘Accurate’ means that you write the facts, rather than your opinion. A reliable way to check if something is a fact or opinion is to ask yourself: can you see, touch, hear, or smell your observation?

To test this out, compare the following statements. Which do you think is fact and which is opinion?

Mary refused to clean her teeth this morning and complained about things as usual.  
Mary refused to clean her teeth this morning; she said she was tired and that her mouth hurt.
The statement on the left contains opinion: ‘complained about things as usual’. It only reflects the PCW being fed up with Mary but nothing they observed on the day. This is inaccurate.

The statement on the right is factually correct. The PCW wrote what Mary did - refused to clean her teeth, and what Mary said - that she was tired and her mouth hurt.

**Dating records**

Records must be made in real time (on or close to the time the observations were made) to be accurate. Make it a habit to write the date, time and year of all your entries.

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<table>
<thead>
<tr>
<th>OPINION</th>
<th>FACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary refused to clean her teeth this morning and complained about things as usual.</td>
<td>Mary refused to clean her teeth this morning; she said she was tired and that her mouth hurt.</td>
</tr>
</tbody>
</table>

Ask yourself:

- Will it make sense in five years’ time?
- Will it make sense to others when they read it?
- Does it give a clear picture of the person/situation?
- Does it add value to the story – is it useful?
Health records contain sensitive information and the law insists on confidentiality and privacy of that information. Confidentiality ensures that details you learn about the person aren’t given to anyone who isn’t authorised to know them. Privacy is respecting a person’s right to protect their personal information.

An important part of your job is storing client information correctly so that privacy and confidentiality can be maintained.

Ask yourself:

- Is all information about the client stored safely?
- How is the information accessed (electronic/paper)?
- Who can access the information?
- Is client information compliant with workplace policies and procedures?

Your workplace or organisation should have a style guide or policy on how to write workplace documentation, including the level of detail you must complete each time you see a client.

Ask your employer for a copy of the documentation policy or requirements. Then you’ll know if you’re compliant.

If your employer doesn’t have a documentation policy or style guide, ask about how you could help to develop one.

All documentation must be compliant with the Health Records (Privacy & Access) Act 1997.
Abbreviations

Make it a habit to only use approved abbreviations. Made-up abbreviations won’t make sense to others, and probably won’t be compliant with your workplace policy or documentation guidelines.

If your workplace has a list of approved abbreviations that you can use in your documentation, list them here:

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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If there are any you are not sure about, check with your organisation to see if they are approved or not.

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Once you have made sure your documentation is person-centred, accurate, and compliant, you must make sure you write enough information to really tell the story. The E of PACED is enough.

Think about who may be reading your documentation and ask yourself:

- Is there enough information to tell the whole story?
- Does the information add value*, or just add words?
- Is the information relevant to the situation?

* ‘Adding value’ means that it is useful. Examples of adding value include giving information to others so they know what’s happening; following an incident; for the client to take to the doctor (eg BGL records).

Here’s an example to explain how this works. The following is written on the record of a PCW visit to support Mr Johnson:

‘It was a bright sunny day when I arrived at Mr Johnson’s house.’
Saying it was ‘bright and sunny’ only adds value, or is relevant, if:

- Mr Johnson fell because the sun was in his eyes when he walked up the steps after putting the washing out;
- YOU fell up the stairs to Mr Johnson’s home because of the sun being in your eyes;
- Mr Johnson was inside reading the paper, when he usually sits on his verandah on sunny days (a variance on his normal behaviour); or
- he said ‘he was happy to be out for the first time that year’ after a period of long illness (a variance, in this case for the better).

EXERCISE: Using the guidelines on ‘enough’, decide whether the following statements give you enough information.

1. ‘Jim helped with breakfast, took meds’
2. ‘All care as per care plan’
3. ‘Asleep ATOR’
4. ‘Settled on leaving’

ANSWERS
1. Not enough: not clear if Jim helped to make breakfast, or whether he was helped to make/eat it, or took his medication or you assisted him with it.
2. Not Enough: detiled notes help remind you and inform others of the care provded
3. Not enough: did client wake up or did you wake them?
4. Enough: if used at the end of a completed note.
Care plans

Care plans are a plan of care – they should clearly tell the reader what to do to support the client. Each care plan must be easy to read and relevant. It must also contain:

- The person’s ability
- The person’s support needs
- Interventions to support the person
- When the care plan should be reviewed / care evaluated

The following case studies are about Molly and Helga. Read though their different situations and then look at their care plans.

Each care plan is written with the PACE method. Note how the plans are about Molly and Helga rather than a list of tasks that need to be completed.

Let’s get started and put these plans through their PACE(s)!
Case study 1 - Molly

Molly is a 93-year-old war widow whose husband served in the Army in World War II. She has lived in the local area all her life and is well known in the community.

Molly’s husband Frank died some years ago, aged 87. Molly misses him and enjoys looking at her photos of them together in years gone by. Molly’s son Brian lives about an hour’s drive away and pops in each week.

Molly is very independent and has refused any offers of help or assistance until a couple of months ago. She lives on her own in a small single-level house.

Following a fall and some sutures to a head wound, Molly realised that she had to have a little help or she may have another fall, which could land her in hospital and possibly long-term care.

Molly’s medications include a tablet for blood pressure and one for diabetes – although she doesn’t believe in “all that rubbish” about diabetes. She’s eaten well all her life, stayed healthy, and refuses to change her diet for anyone.

Molly takes an occasional headache tablet. None of her medications are packed, and she independently self-administers all medications.

A comprehensive nursing assessment has been completed by the registered nurse, which formed the basis of Molly’s care plan – see next page.
## Care plan: Molly Jones

<table>
<thead>
<tr>
<th>Number</th>
<th>Ability / Support Need</th>
<th>Planned Intervention</th>
<th>RN/PCW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Personal Care</td>
<td></td>
<td>RN/PCW</td>
</tr>
<tr>
<td></td>
<td>Goal - Molly is supported with effective personal and skin care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly can dress and undress with some help to fasten her bra and put on her stockings as she gets dizzy when she bends down</td>
<td>• Assist Molly to wash her back during shower and to wash her hair (usually Mondays)</td>
<td>PCW</td>
</tr>
<tr>
<td></td>
<td>• Molly can shower independently with help to wash her back; she has a shower twice a week (Mondays and Thursdays) and has a strip wash on other days.</td>
<td>• Ensure Molly has privacy until she requires assistance with washing her back</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly needs help to wash her hair each week – usually on Monday</td>
<td>• Discreetly check Molly’s skin integrity, signs of redness, skin tears or bruising. Check nails; assist to file if required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly requires help with dressing</td>
<td>• Assist with drying Molly’s back and applying moisturiser</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assist Molly to fasten her bra and put on her stockings</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Ensure wheelie walker is close by when Molly stands up after getting dressed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mobility</td>
<td></td>
<td>PCW</td>
</tr>
<tr>
<td></td>
<td>Goal - Molly is supported to be as independent as possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly uses a wheelie walker around the house to assist in her mobility.</td>
<td>• Encourage Molly to use wheelie walker to move safely around her house and rest as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly sits on her wheelie walker to rest if she feels tired.</td>
<td>• Encourage Molly to use wheelie walker when getting out of chair and walker is within reach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly uses a wheelie walker to assist her moving from chair to standing</td>
<td>• Ensure wheelie walker is close to bed and easily reached by Molly when she is in bed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly is at risk of increased falls / previous fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Ability / Support Need</td>
<td>Planned Intervention</td>
<td>RN/PCW</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>3</td>
<td>Skin integrity</td>
<td></td>
<td>RN/PCW</td>
</tr>
<tr>
<td></td>
<td>Goal - Molly's skin integrity is maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly will tell staff if she notices any changes in her skin condition, such as graze or tear</td>
<td>• Assist Molly to check her skin daily for any changes such as redness, graze or tear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly will have skin protected from potential damage by comfortable clothing that fits well</td>
<td>• Assist Molly when dressing to ensure there are no creases in her clothing, no pinches from her clothing such as her bra and no tight restraints such as tight stockings or socks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molly understands the importance of moving around regularly and not sitting or lying in one position for too long</td>
<td>• Check shoes to ensure well-fitting / no rough points</td>
<td>PCW</td>
</tr>
<tr>
<td></td>
<td>• Molly will be positioned safely to reduce chances of breakdown in skin integrity</td>
<td>• Encourage Molly to move around every couple of hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discreetly observe Molly’s skin condition when assisting during personal care; report variance to registered nurse</td>
<td>• Discreetly observe Molly’s skin condition when assisting during personal care; report variance to registered nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist Molly when changing position in chair or bed to ensure there are no creases in clothing or bedding or objects underneath her that may rub on her skin and cause skin breakdown</td>
<td>• Assist Molly when changing position in chair or bed to ensure there are no creases in clothing or bedding or objects underneath her that may rub on her skin and cause skin breakdown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Observe for any signs of fall – bruising, skin tears. Report any changes to registered nurse and document in progress notes and on incident form</td>
<td>• Observe for any signs of fall – bruising, skin tears. Report any changes to registered nurse and document in progress notes and on incident form</td>
<td></td>
</tr>
</tbody>
</table>
Case study 2 - Helga

Helga is 68 years old and has early onset dementia. She served as a Nursing Officer in the Army during the Vietnam War. She lives at home with her husband Peter, who works part-time. Helga and Peter have two adult children, Chris and Amy, who visit regularly and help as needed.

Helga needs prompting and supervision to complete tasks. She can prepare meals but may forget safe food handling. She also needs prompting to finish meals as she may wander away from the table if something interests her or she is preoccupied. She also needs to be reminded of appointments.

Helga needs prompting to take her medications from a blister pack. She likes to fold clean laundry but will sometimes hide dirty underwear in drawers.

Security is important to Helga, and she can get upset if a visitor arrives at her house and she has forgotten they are coming. If she doesn’t feel safe, she may leave her home. Previously her family found her walking a few streets away near busy traffic, wearing only her pyjamas and slippers.

Sometimes Helga leaves things unsecured, such as leaving money around the house. She will also give money to strangers if they ask for it.

A comprehensive nursing assessment has been completed by the registered nurse, which formed the basis of Helga’s care plan – see next page. Helga needs prompting to take her medications at lunchtime when Peter is at work, preparation of lunch and observation to ensure she completes her meal.
## Care plan: Helga Hammond

<table>
<thead>
<tr>
<th>Number</th>
<th>Ability / Support Need</th>
<th>Planned Intervention</th>
<th>RN/PCW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Behaviours</td>
<td>Helga is supported to ensure her physical and psychological safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Helga likes to feel secure</td>
<td>Always ring doorbell before attempting to gain access</td>
<td>PCW</td>
</tr>
<tr>
<td></td>
<td>• If Helga does not feel safe and secure she will leave the house</td>
<td>If Helga doesn’t answer the door, access key in key-safe and knock as you enter the house calling “Hi Helga, it’s (name) come to see you for lunch”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Helga can leave things unsecured</td>
<td>Reassure Helga that you are allowed to visit – she likes to see ID</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Explain that you are there to visit with Helga and remind her to take her tablets – ask her to fetch her blister pack from the TV cabinet</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Write on the whiteboard who has visited and at what time</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Medications</td>
<td>Helga has all medications administered safely and correctly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Helga requires prompting to take oral medications and supervision to ensure she has taken her medications</td>
<td>Remind Helga to take her medications from the blister pack on the TV cabinet</td>
<td>PCW</td>
</tr>
<tr>
<td></td>
<td>• Helga’s medications are packed into a blister pack</td>
<td>Observe Helga taking her medications; she will do so independently with a gentle reminder and a glass of water</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Helga has non-prescribed rehydrating eye drops</td>
<td>Administer non-prescribed eye drops twice each day as per instructions from family</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Report any variance to the registered nurse</td>
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</tr>
</tbody>
</table>
Progress notes

Progress notes are a way to document a person’s progress. Your workplace will have a policy on how often a progress note must be completed and the type of things to include.

ALL progress notes must be PACED and comply with the law. Look at the notes you write and see if you can tick all the boxes below:

| Client identification is clearly visible on each page – full name and / or reference number. |
| Notes are in a clear order – as they occur. |
| The signature, name and designation of the writer is documented at each entry eg: **N Jones**, Nancy JONES - PCW. |
| Each entry has the date, time and year included. Dates and times to be written consistently – 12 or 24 hour clock. |
| Notes are made in real time – at the time of the visit or very soon after. |
| Interventions (what you did) are documented. |
| Specific areas of care are documented – in line with the care plan. |
| Variances are documented accurately (remember, use your senses!) You may need an incident form too. |

Let’s look at why these points are so important.
Client identification is clearly visible on each page

- Clear identification ensures that the right notes are kept in the right place! If any progress notes do become separated from the client file and found somewhere else, it is easier to see who’s file they belong to. Each page of progress notes MUST have the person’s full name, not just a first or last name.

- Reference numbers are used to separate two people with the same or similar names. This can be important when care is provided to two people such as a husband and wife or two siblings who both receive care.

- Whilst numbers can seem a bit impersonal, they are very useful as they are unique to that person, unlike a name, which can be similar to another.

Notes are in a clear order – as they occur

- Progress notes are designed to tell a story; having notes in a clear order makes it easier for the reader to understand the story about the person.

- Imagine having to read a novel where there is a chapter missing, then you find it later in the book. When you start reading the chapter, you remember thinking there was something missing, so you have to go back to the earlier part of the story to remember what actually happened. This makes it difficult for the reader and it is the same with progress notes.
Who wrote the note?

- Progress notes must be kept for a minimum of seven years to comply with legislation.

- In five years, you may be working for another organisation, supporting different clients, or living in a different area.

- Progress notes are often reviewed as part of a complaint investigation, legal or coroner’s case. In this event it is essential to know who assisted the person and what position they held.

- Your clear name after your signature, together with your designation (job title) helps to identify you - N Jones, Nancy JONES – PCW. This should be included every time you complete a progress note.

When was the progress note written?

- When we look back at client records, the date, time and year all help to place the progress note at the right time.

- Time must be written consistently – either 12- or 24-hour clock. Check with your workplace how you should write the time. Using simply AM and PM is not specific enough.

- If you use the 12-hour clock you should use AM and PM to identify the period of the day, for example 7.15am; 9.40pm

- If you use the 24-hour clock, do not use AM or PM – the time replaces them, for example 0715hrs; 2140hrs.
Notes are made in real time

- Plans often change – you may be asked to visit a different person at short notice; you may have to leave work early if a child is sick; you may be asked at short notice to visit a person who you haven’t assisted before. Reading someone else’s ‘real time’ notes can help us.

- You should record your notes in ‘real time’ - that is at the time of the visit or very soon after. We do this so that we don’t have to rely on our memory when writing the note a long time later. We get a more accurate progress note when we don’t have to rely on our memory too much!

Document interventions and specific areas of care

- Can you remember what you wrote two years ago? Can you remember the exact things you assisted someone with last month? Can you remember the exact spot that Molly complained about yesterday?

- Most people can’t, and that’s why we record interventions in progress notes.

- Investigations into complaints about a person’s care or allegations of neglect often criticise the quality and the detail of the progress notes.
Exercise: Improving progress note entries

Imagine you are reading another PCW’s progress notes on Molly (see case study). The PCW documented today’s visit with four notes:

1. Molly helped with breakfast, took meds
2. All care as per care plan
3. Asleep ATOR
4. Settled on leaving

Thinking about PACE, how useful and accurate are these notes? Are they enough? **Are they person-centred?**

Re-write them here using the PACE method and follow the progress notes guidelines opposite. Feel free to make up details – practise your PACE!

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________________________________________________________________________
Here are some progress notes about Helga. Rewrite them using PACE.

| More confused than usual thought it was Wednesday |
| Pale |
| Tried to leave, back door |
| Had meds |
Incident reports

In this booklet we have discussed ‘variances’ – changes in a client’s usual health and wellbeing.

Dramatic and sudden variances require you to act quickly to manage, observe and directly report the situation. Once the situation is under control, you will need to document it.

For example, if you arrive and discover a client has had a fall and is bleeding from the head:

- Manage and observe, apply first aid to treat bleeding. If unconscious and/or bleeding heavily, call 000.
- Report immediately, for example, to your manager who will then notify person’s next of kin.
- When situation is under control, make progress notes and start an incident report (check your workplace policy and procedure for reporting incidents).
- Send an email to relevant people, as an immediate record of the event.
- If the situation involves actual or suspected abuse/assault you must report it immediately. For more information, refer to your organisation’s guidelines on mandatory reporting.

When writing an incident report, you should use the same PACE methods. For example, include:

- what you observed (not your opinion)
- what happened in the order that things happened
- who was there, and at what times
- include relevant details only.
Remember, when completing any client documentation, to consider whether it is PACED!

- Person-centric
- Accurate
- Enough
- Compliant
Appendix 1: NSS - Common activities by intervention

This table contains the NSS scope of practice. A NSS can complete all the listed activities. For further information ask your employer or look at The Notes for Community Nursing Providers.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>PC activity</th>
</tr>
</thead>
</table>
| Aids / appliances  | • Fitting aids and appliances  
<pre><code>               |   • Includes splints, callipers, compression stockings or garments          |
</code></pre>
<p>| Medication         | • Prompting self-administration of medication from a packaged system        |
|                    | • Assisting self-administration of medications                             |
|                    | • Reminding client to take medications                                     |
|                    | • Non-prescribed eye drops                                                 |
|                    | • Non-prescribed eye ointment                                              |
|                    | • Non-prescribed skin cream / lotion                                       |
|                    | • Cortisone cream (prescribed or non-prescribed)                           |
| Mobility           | • Transferring using manual handling equipment                             |
| Nutrition - input  | • Observation of intake / recording                                        |
| Output             | • Observation                                                             |
|                    | • Assistance going to the toilet                                           |
|                    | • Collection of urine or faeces specimen                                   |
|                    | • Changing catheter bag                                                   |
|                    | • Emptying catheter bag                                                   |
|                    | • Cleaning catheter site                                                  |
|                    | • Assistance with application of stoma appliance where                     |
|                    |   the entitled person maintains responsibility for care                    |
|                    | • Perineal care                                                           |</p>
<table>
<thead>
<tr>
<th>Intervention</th>
<th>PC activity</th>
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</table>
| Personal Hygiene          | • Shower  
                          • Bed bath / assisted wash  
                          • Assistance with dressing and grooming |
| Respiratory care          | • Assist with self-care administration of oxygen      |
| Skin integrity            | • Maintenance of skin integrity                       |
| Wound management          | • Basic first aid treatment                           |
### Abbreviations and glossary

<table>
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<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>Client</td>
<td>A person who uses the services provided by DVA; this can be a veteran or a veteran spouse or dependent. They are described as an ‘entitled person’.</td>
</tr>
</tbody>
</table>
| NSS          | Nursing Support Staff  
Other names used to describe this role include:  
• PCW (personal care worker)  
• CSE (care services employee)  
• AIN (assistant in nursing)  
• PCE (personal care employee)  
• PCA (personal care assistant)  
• HCA (health care assistant or home care assistant) |
<p>| PTSD         | Post-traumatic stress disorder |
| VVCS         | Veterans and veterans’ family counselling service (now called Open Arms) |</p>
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<th>DVA Contacts and Resources</th>
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<td>Community Nursing Website</td>
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<td>Veterans’ Home Care</td>
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<td>Open Arms - Veterans and Families Counselling</td>
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